Alameda Head Start/Early Head Start

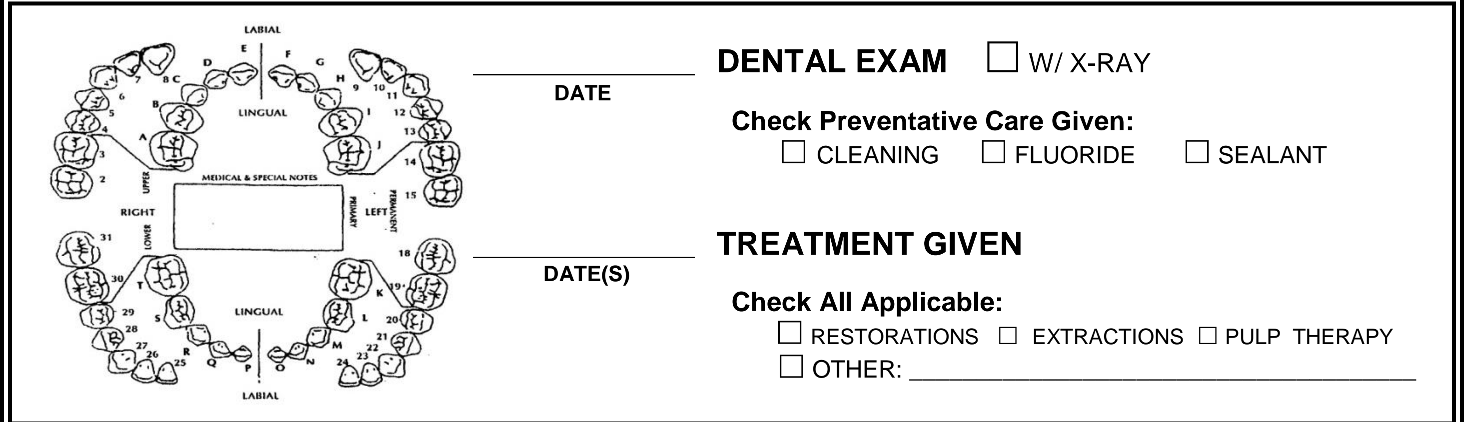
DENTAL EXAM REPORT

(For Expectant Mothers & Children >12 Months)

Patient's Name: ____DOB: ____________

TO BE COMPLETED BY DENTIST/CLINIC:

SOURCE OF PAYMENT: ☐ **CHDP** ☐ **HEALTHY FAMILIES** ☐ **MEDI-CAL** ☐ **PRIVATE** ☐ **SELF PAID**



_______________ DATE

DENTAL EXAM ☐ W/ X-RAY

Check Preventative Care Given:
☐ CLEANING ☐ FLUORIDE ☐ SEALANT

_______________ DATE(S)

TREATMENT GIVEN

Check All Applicable:
☐ RESTORATIONS ☐ EXTRACTIONS ☐ PULP THERAPY
☐ OTHER: ____________________________________

CURRENT STATUS: (Please check all that apply)

☐ NO ADDITIONAL TREATMENT NEEDED AT THIS TIME.

☐ TREATMENT IN PROGRESS. Follow-up appointment scheduled for: ________________________________
DATE(S)

# of ______Restorations # of ______Pulp Therapy # of ______Extractions Other________________

☐ TREATMENT COMPLETED.

COMMENTS: ____

____

Dentist\Clinic Name and Address **Phone Number** **Date**

TO BE COMPLETED BY PATIENT/LEGAL GUARDIAN:

I consider this Dentist/Dental Clinic to be my child's primary dental care provider: ☐ **YES** ☐ **NO**

I authorize Alameda Head Start/Early Head Start staff and to exchange information related to this dental exam while the patient is enrolled in the Alameda Head Start/Early Head Start program, and understand that the information shared will be kept confidential within the Alameda Head Start/Early Head Start program guidelines.

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Applicant or Parent /Guardian's Signature **Date**